SERFF Tracking Number:	*MUTM-128441091*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*ELLEN GRADY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*2012 IBOBA (Amway) - 12345GCB-LTD-EZ 11*		
Project Name/Number:	*2012 IBOBA (Amway)/12345GCB-LTD-EZ 11*		

Filing at a Glance

Company: United of Omaha Life Insurance Company

Product Name: 2012 IBOBA (Amway) - 12345GCB-LTD-EZ 11	SERFF Tr Num: MUTM-128441091	State: Arkansas
TOI: H11G Group Health - Disability Income	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: H11G.003 Long Term	Co Tr Num: ELLEN GRADY	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: June Rodgers, Mary Gregg, Krysia Gannon, Kristin Miller, Lisa Koch, Ellen Grady	Disposition Date: 06/11/2012
	Date Submitted: 06/01/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 2012 IBOBA (Amway)	Status of Filing in Domicile:
Project Number: 12345GCB-LTD-EZ 11	Date Approved in Domicile:
Requested Filing Mode: Informational	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Large
Group Market Type: Association	Overall Rate Impact:
Filing Status Changed: 06/11/2012	
State Status Changed: 06/11/2012	Deemer Date:
Created By: Krysia Gannon	Submitted By: Mary Gregg
Corresponding Filing Tracking Number:	
Filing Description:	
NAIC # 261-69868	

Group Voluntary Long-Term Disability certificate booklet 12345GCB-LTD-EZ 11

This submission is an informational, extraterritorial filing for the Independent Business Owners Benefits Association (IBOBA), an association group that is situsedin Michigan.

SERFF Tracking Number:	*MUTM-128441091*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*ELLEN GRADY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*2012 IBOBA (Amway) - 12345GCB-LTD-EZ 11*		
Project Name/Number:	*2012 IBOBA (Amway)/12345GCB-LTD-EZ 11*		

The Independent Business Owners Benefits Association was created by Amway - a direct-selling company that produces consumer products - for the benefit of its independent business owners who sell Amway products. Copies of the association's bylaws and articles of incorporation are attached as supporting documentation.

This certificate booklet will be issued with master policy 7000GM-U-EZ 2010, approved December 29, 2010, under SERFF tracking number MUTM-126940969.

Your review of this submission is greatly appreciated. Please contact me with any questions or concerns.

Sincerely,

Ellen Grady
Product and Advertising Compliance Analyst
Corporate Compliance and Ethics Division
Phone: 402-351-2484
Fax: 402-351-5298
E-mail: ellen.grady@mutualofomaha.com

State Narrative:

Company and Contact

Filing Contact Information

Ellen Grady, Product & Advertising Compliance Analyst	ellen.grady@mutualofomaha.com	
Mutual Of Omaha	402-351-2484 [Phone]	
Mutual of Omaha Plaza	402-351-5298 [FAX]	
Omaha, NE 68175		

Filing Company Information

United of Omaha Life Insurance Company	CoCode: 69868	State of Domicile: Nebraska
Mutual of Omaha Plaza	Group Code: 261	Company Type: Life Insurance
Omaha, NE 68175	Group Name:	State ID Number:
(402) 351-6910 ext. [Phone]	FEIN Number: 47-0322111	

SERFF Tracking Number:	*MUTM-128441091*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*ELLEN GRADY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*2012 IBOBA (Amway) - 12345GCB-LTD-EZ 11*		
Project Name/Number:	*2012 IBOBA (Amway)/12345GCB-LTD-EZ 11*		

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United of Omaha Life Insurance Company	$0.00	06/01/2012	
United of Omaha Life Insurance Company	$50.00	06/04/2012	59659893

SERFF Tracking Number:	*MUTM-128441091*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*ELLEN GRADY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*2012 IBOBA (Amway) - 12345GCB-LTD-EZ 11*		
Project Name/Number:	*2012 IBOBA (Amway)/12345GCB-LTD-EZ 11*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/11/2012	06/11/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	06/05/2012	06/05/2012	Krysia Gannon	06/05/2012	06/05/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Your Group Voluntary Term Life Benefits	Mary Gregg	06/04/2012	06/04/2012

SERFF Tracking Number:	*MUTM-128441091*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*ELLEN GRADY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*2012 IBOBA (Amway) - 12345GCB-LTD-EZ 11*		
Project Name/Number:	*2012 IBOBA (Amway)/12345GCB-LTD-EZ 11*		

Disposition

Disposition Date: 06/11/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MUTM-128441091*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*ELLEN GRADY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*2012 IBOBA (Amway) - 12345GCB-LTD-EZ 11*		
Project Name/Number:	*2012 IBOBA (Amway)/12345GCB-LTD-EZ 11*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	IBOBA Articles of Inc and Bylaws	Approved-Closed	Yes
Form	Your Group Voluntary Long-Term Disability Benefits	Approved-Closed	Yes
Form *(revised)*	Your Group Voluntary Term Life Benefits	Withdrawn	No
Form	Your Group Voluntary Term Life Benefits	Withdrawn	No

SERFF Tracking Number:	*MUTM-128441091*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*ELLEN GRADY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*2012 IBOBA (Amway) - 12345GCB-LTD-EZ 11*		
Project Name/Number:	*2012 IBOBA (Amway)/12345GCB-LTD-EZ 11*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/05/2012
Submitted Date	06/05/2012
Respond By Date	

Dear Ellen Grady,

This will acknowledge receipt of the captioned filing.

Objection 1

- IBOBA Articles of Inc and Bylaws (Supporting Document)

Comment:

Before final review is given to this submission, it is requested that you answer the questions and/or supply the additional information outlined in the attached questionnarie.

We appreciate your cooperation.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

We have received your filing regarding the above named association/ discretionary group. To determine if this organization is a qualified group under our statutes, please provide the answers to the following questions:

1. Name and address of the group.
2. Is this group incorporated? If so, give state of incorporation.
3. Is there a current office in Arkansas?
4. Does the Arkansas part of the organization have any officers, committees, or chapters? If so, give details.
5. Are annual dues charged? If so, specify amount.
6. What are the specific activities of the organization?
7. What benefits are provided to the members in addition to insurance? PLEASE ATTACH BROCHURES ON THE BENEFITS.
8. What qualifies an individual for membership?
9. How are members recruited? If by mailing list, advise the source of this list.
10. Attach a copy of the organization by-laws.
11. Also, enclose a list of dues paying members residing in Arkansas with full addresses. If the organization considers this privileged information, we will treat it as such and once it has served our purpose, it will be destroyed.
12. Please attach a copy of the organization's most recent financial statement.
13. Does the organization receive any compensation of any kind from the insurer issuing contracts to its members?

Approval of the organization as a qualified group for insurance purposes will be determined upon receipt of your reply.

SERFF Tracking Number:	*MUTM-128441091*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*ELLEN GRADY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*2012 IBOBA (Amway) - 12345GCB-LTD-EZ 11*		
Project Name/Number:	*2012 IBOBA (Amway)/12345GCB-LTD-EZ 11*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/05/2012
Submitted Date	06/05/2012

Dear Rosalind Minor,

Comments:
Thank you for your review of this filing. Our answers to the questionnaire included with your objection letter dated June 5, 2012, are below.

Response 1

Comments: 1. Name and address of the association. Independent Business Owners Benefits Association, 7575 Fulton Street East, Ada, MI 49355-0001
2. Is this association incorporated? If so, give state of incorporation. Michigan
3. Is there a current office in Arkansas? No
4. Does the Arkansas part of the organization have any officers, committees, or chapters? If so, give details. Not applicable.
5. Are annual dues charged? If so, specify amount. A member must register with Amway as an Independent Business Owner (IBO), which costs $62 year.
6. What are the specific activities of the association? To promote the interests of the members of the corporation at the local, state and federal government levels, to use the power of group buying to make available to the members benefits and services such as travel programs, including automobile rental and hotel discounts, insurance, non-insurance healthcare discounts, and to provide educational information and forums.
7. What benefits are provided to the members in addition to insurance? ATTACH BROCHURES ON THE ASSOCIATION WHICH OUTLINES THE ADDITIONAL BENEFITS. Please see amway.com>more products>partner stores & services. Amway has not added marketing language to their website promoting discounts & benefits of IBOBA as they continue to focus on the Amway branding and the actual branding of the service to do this. IBO recognize the names like Avis, Budget, Days Inn, Choice Hotels, Ramada, Howard Johnson, Travel Lodge, Wells Fargo vs IBOBA.
8. What qualifies an individual for membership? Independent business owner (IBO)
9. How are members recruited? If by mailing list, advise the source of this list Members find the insurance offering available on the website. Neither the IBOBA or Amway do a mailing about the insurance offerings. Amway.com is where all IBOs go to buy products and services.
10. Attach a copy of the association's Articles of Incorporation and By Laws. OK
11. Enclose a list of dues paying members residing in Arkansas with full addresses. If the association considers this privileged information, we will treat it as such and once it has served our purpose, it will be destroyed. IBOBA & Amway consider this confidential information and will not provide names & addresses. We respectfully request your department

provide a reason why this is necessary before we request this information.

12. Please attach a copy of the associations most recent financial statement. As IBOBA is a nonprofit corporation, there are no financial statements.

13. Does the association receive any compensation of any kind from the insurer issuing contracts to its members? No

Related Objection 1

Applies To:

- IBOBA Articles of Inc and Bylaws (Supporting Document)

Comment:

Before final review is given to this submission, it is requested that you answer the questions and/or supply the additional information outlined in the attached questionnarie.

We appreciate your cooperation.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your continued review of this filing.

Sincerely,
Ellen Grady, June Rodgers, Kristin Miller, Krysia Gannon, Lisa Koch, Mary Gregg

SERFF Tracking Number:	*MUTM-128441091*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*ELLEN GRADY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*2012 IBOBA (Amway) - 12345GCB-LTD-EZ 11*		
Project Name/Number:	*2012 IBOBA (Amway)/12345GCB-LTD-EZ 11*		

Amendment Letter

Submitted Date: 06/04/2012

Comments:

We are withdrawing form 7000CI-U-EZ 10 as it was submitted in error. We apologize for this oversight and any confusion it may have caused. Thank you.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
7000CI-U-EZ 10	Certificate	Your Group Voluntary Term Life Benefits	Other	WITHDRAWN			40.000	

SERFF Tracking Number:	*MUTM-128441091*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*ELLEN GRADY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*2012 IBOBA (Amway) - 12345GCB-LTD-EZ 11*		
Project Name/Number:	*2012 IBOBA (Amway)/12345GCB-LTD-EZ 11*		

Form Schedule

Lead Form Number: 12345GCB-LTD-EZ 11

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/11/2012	12345GCB-LTD-EZ 11	Certificate	Your Group Voluntary Long-Term Disability Benefits	Initial		43.800	12345GCB-LTD-EZ 11.pdf
Withdrawn 06/11/2012	7000CI-U-EZ 10	Certificate	Your Group Voluntary Term Life Benefits	Other	Other Explanation: WITHDRAWN	40.000	

YOUR GROUP VOLUNTARY LONG-TERM DISABILITY BENEFITS

FOR MEMBERS OF:

Independent Business Owners Benefits Association

CLASS(ES):

All Active Independent and Non-Independent Business Owners (IBO) Not Engaged in Non-Preferred Industries

All Active Independent and Non-Independent Business Owners (IBO) Engaged in Non-Preferred Industries

EFFECTIVE DATE:

April 1, 2012

PUBLICATION DATE:

April 4, 2012

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. BENEFITS ARE PROVIDED THROUGH A GROUP POLICY ISSUED IN THE STATE OF MICHIGAN.

FOR RESIDENTS OF FLORIDA
THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

FOR RESIDENTS OF MARYLAND
THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL OF THE BENEFITS REQUIRED BY MARYLAND LAW.

FOR RESIDENTS OF NORTH CAROLINA
THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN NORTH CAROLINA. PLEASE READ YOUR POLICY CAREFULLY.

FOR RESIDENTS OF VERMONT
THIS POLICY OR CERTIFICATE IS NOT SUBJECT TO REGULATION BY VERMONT.

FRAUD WARNING
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

If You have any questions about or concerns with this insurance, please first contact the Policyholder or Your benefits administrator. If, after doing so, You still have a question or concern, You may contact Us at:

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-877-5176
www.mutualofomaha.com

When contacting Us, please have Your Policy number available.

After the above contact, and if Your problem is not resolved, You may contact the department of insurance in Your state of residence. We will provide You with contact information for the department of insurance in Your state upon request.

TABLE OF CONTENTS

THIS PAGE INTENTIONALLY LEFT BLANK

CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number GUPR-AKS5 (the Policy) has been issued to Independent Business Owners Benefits Association (the Policyholder).

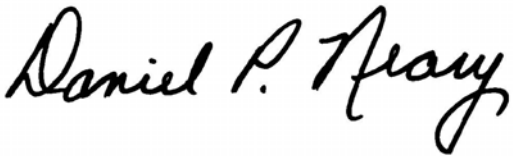
Insurance is provided for Members of the Policyholder subject to the terms and conditions of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if You are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without Your consent or notice to You.

This Certificate replaces any certificate previously issued under the Policy.

UNITED OF OMAHA LIFE INSURANCE COMPANY



Chairman of the Board and Chief Executive Officer

Corporate Secretary

SCHEDULE

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

CLASS(ES)

Class I: All Active Independent and Non-Independent Business Owners (IBO) Not Engaged in Non-Preferred Industries

Class II: All Active Independent and Non-Independent Business Owners (IBO) Engaged in Non-Preferred Industries

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Basic Monthly Earnings means Your average net monthly earnings from salary, wages, bonuses, commissions, fees or other payments received for personal services rendered or work performed in any occupation. The average is based on Your net monthly earnings for the most recent 12-month or 24-month period, whichever produces the higher average. Normal and usual business expenses (as used in accepted accounting practices and procedures for tax purposes) are to be deducted. Income taxes are not to be deducted. Basic monthly earnings does not include dividends, rents, royalties, annuities or other forms of unearned income. Proof of Earnings is required.

Other Income Source(s) has the meaning set forth in the Other Income Sources provision of this Schedule.

Recurrent Disability means a Disability which is caused by, attributable to, or resulting from the same Injury or Sickness that caused the prior Disability for which You received a Monthly Benefit under the Policy.

Reimbursement Agreement means the written agreement that We provide to You under which You agree to repay Us any overpayment resulting from Your or Your Spouse's or child(ren)'s receipt of Other Income Sources.

ELIMINATION PERIOD

The Elimination Period is 90 calendar days.

For purposes of accumulating days of Disability to satisfy the Elimination Period, the following will apply:

a) a period of Disability will be treated as continuous during the Elimination Period unless Disability stops for more than 90 accumulated days during the Elimination Period; and
b) days in which You return to work for a full work day, as verified by records from Your employer(s) if available, will not count towards the Elimination Period.

The Elimination Period begins on the first day of Disability. If You are not continuously Disabled, the Elimination Period must be satisfied within a period of time which does not exceed two times the length of the Elimination Period; otherwise, a new Elimination Period will apply.

RECURRENT DISABILITY

A Recurrent Disability will be treated as part of Your prior claim and You will not be required to satisfy a new Elimination Period if:

a) You were continuously insured under the Policy from the date benefits ended for Your prior claim to the date Your Recurrent Disability begins; and
b) Your Recurrent Disability occurs within 180 days after the date benefits ended for Your prior claim.

In order to prevent over-insurance because of duplication of benefits, benefits payable under this Recurrent Disability provision will cease if benefits are payable to You under any other Policyholder sponsored group long-term disability income policy or plan.

MONTHLY BENEFIT

If You are a Member of Class I, You may elect to be insured for a monthly disability benefit amount from $500 to $6,000, in increments of $100.

If You are a Member of Class II, You may elect to be insured for a monthly disability benefit amount equal to $500.

The amount You elect is Your Monthly Benefit. If You have questions regarding Your elected benefit amount, You may contact the Policyholder or Benefits Administrator.

Total Disability

If You are Disabled and satisfy the Occupation Test and/or You are earning less than 20% of Your Basic Monthly Earnings, the Monthly Benefit while Disabled is the benefit amount elected by You at Your time of enrollment or application, not to exceed 60% of Your Basic Monthly Earnings, less any Other Income Sources.

Partial Disability

As an incentive to work while Disabled, You will receive the Monthly Benefit for 12 months of Disability, unless the sum of:

a) the Gross Monthly Benefit while You are Disabled; plus
b) Cu rrent Earnings;

exceeds 100% of Your Basic Monthly Earnings. If this sum exceeds 100% of Your Basic Monthly Earnings, the Monthly Benefit will be reduced by that excess amount.

After the Monthly Benefit has been paid for an aggregate of 12 months, benefits will be paid according to the following:

a) if You are Disabled under the Occupation Test and/or You earn less than or equal to 20% of Your Basic Monthly Earnings under the Earnings Test, We will pay the Monthly Benefit for Total Disability.
b) if You are Disabled and earn more than 20% of Your Basic Monthly Earnings, We will pay the Monthly Benefit for Partial Disability as calculated below:

(A divided by B) times C

A = Your Basic Monthly Earnings less any Current Earnings
B = Your Basic Monthly Earnings
C = The Monthly Benefit for Total Disability

MINIMUM BENEFIT

As long as You are Disabled Your Monthly Benefit will never be less than $100, unless We reduce the Monthly Benefit to recover an overpayment. If We reduce the Monthly Benefit to recover an overpayment, Your Monthly Benefit may be reduced to zero until We fully recover the overpayment.

When less than one month of Disability benefits is due, a pro rata benefit will be paid for each day of Disability. This pro rata benefit will be equal to 1/30th of Your Monthly Benefit.

VOCATIONAL REHABILITATION BENEFIT

While You are participating in a plan of vocational rehabilitation approved by Us, Your Monthly Benefit will be increased by 5%.

MAXIMUM BENEFIT PERIOD

If You are Disabled because of an Injury or Sickness, We will pay benefits as follows, subject to any limitations described in this Certificate.

The Maximum Benefit Period is 2 (two) years.

OTHER INCOME SOURCES

We take into account the total of all Your income from other sources of income in determining the amount of Your Monthly Benefit. Your Other Income Sources are any of the following amounts that You receive or are eligible to receive as a result of Your Disability or the Sickness and/or Injury that caused, in whole or in part, Your Disability:

a) Any amount under:
   1. a workers' compensation law;
   2. an occupational disease law;
   3. the Jones Act, (46 U.S.C. Statute 688(a) (1920)); or
   4. any other act or law of like intent to the laws described in 1, 2 or 3 above.

b) Any amount under another Policyholder sponsored group short-term or long-term disability insurance policy or plan or Policyholder sponsored individual short-term or long-term disability insurance policy or plan, except any group short-term or long-term disability insurance policy or plan underwritten by United of Omaha Life Insurance Company.

c) Any amount as disability income payments under any:
   1. state compulsory benefit act or law;
   2. government retirement system as a result of Your job with the Policyholder or any other employer; or
   3. work loss provision in a no-fault motor vehicle insurance plan, unless state law or regulation does not allow group disability income benefits to be reduced by benefits from no-fault motor vehicle coverage.

d) Any benefits for You or Your Spouse or Your Dependent Child under:
   1. the U.S. Social Security Act;
   2. the Canada Pension Plan;
   3. the Quebec Pension Plan;
   4. the Railroad Retirement Act;
   5. any public employee retirement plan;
   6. any teachers employment retirement plan; or
   7. any similar plan or act that provides:
      a. Disability benefits; or
      b. retirement benefits (except this will not apply if Your Disability begins after Your Social Security Normal Retirement Age and You were already receiving Social Security retirement benefits. This exception only applies to U.S. Social Security Benefits).

e) Any amount payable as;
   1. salary continuance, except
      a. paid time off (PTO) that is not specified as sick leave;
      b. vacat ion;
      c. any earned time off program;
   2. sick leave; or
   3. severa nce allowance.

f) Any amount from a third party (after subtracting attorneys' fees) by judgment, settlement or otherwise.

g) Any amount from any unemployment insurance law or program.

EXPLANATION OF OTHER INCOME SOURCES

You must apply for Other Income Sources for which You are or may become eligible, including but not limited to Social Security disability and/or dependent benefits, and do what is needed to obtain them. If Your application is denied, We may require that You appeal the decision to a level that is satisfactory to Us and provide written proof of all levels of appeal.

As part of Your proof of Disability, We require that You furnish evidence to Us that You have applied for Other Income Sources for which You are or may become eligible.

After the initial reduction for each type of Other Income Sources, We will not further reduce Your Monthly Benefit due to any cost of living increases payable under such type of Other Income Sources.

Other Income Sources that are paid in a lump sum will be prorated on a monthly basis over a period for which the sum is given. If no time period is stated, the sum will be prorated on a monthly basis over the lesser of the following:

a) the Policy's Maximum Benefit Period; or
b) 60 equal payments.

If Other Income Sources are paid on a retroactive basis, We may reduce or suspend the Monthly Benefit to recover any overpayment.

Regardless of how funds from a Retirement Plan are distributed, We will consider Your contributions and the Policyholder or any other employer's contributions to be distributed simultaneously during Your lifetime.

We will pay the full amount of the Monthly Benefit if You:

a) apply for Other Income Sources; and
b) sign Our Reimbursement Agreement.

Until You have signed Our Reimbursement Agreement and have given written proof to Us that application has been made or all available appeals have been exhausted for Other Income Sources, We may:

a) estimate Your Other Income Sources; and
b) reduce Your Monthly Benefit by that amount.

If We reduce Your benefit on this basis, and if all of Your appeals are denied, We will restore Your Monthly Benefit amount and refund any underpayment to You in a lump sum.

ASSISTANCE WITH FILING FOR SOCIAL SECURITY DISABILITY BENEFITS

We can arrange for advice regarding Your claim for Social Security disability benefits and assist You with Your application or appeal. In order to be eligible for assistance, You must be receiving Monthly Benefits from Us.

Receiving Social Security disability benefits may enable:

a) You to receive Medicare after 24 months of disability payments;
b) You to protect Your Social Security retirement benefits; and
c) Your family to be eligible for Social Security disability benefits.

We can arrange assistance in obtaining Social Security disability benefits by:

a) helping You find appropriate representation;
b) obtaining medical and vocational evidence; and
c) reimbursing pre-approved case management expense.

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Actively Eligible, Active Eligibility means a Member is:

a) eligible for insurance according to the Policyholder or Benefit Administrator's rules of eligibility as approved by Our authorized representative in Our home office; and
b) eligible for insurance under the Policy in accordance with the terms and conditions of this Eligibility section.

If the Policyholder or Benefit Administrator's rules of eligibility for insurance conflict with any of the terms and conditions of this Eligibility section, the terms and conditions of this Eligibility section shall control. Any changes to the Policyholder or Benefit Administrator's rules of eligibility after the Policy Effective Date will not be effective for purposes of becoming or remaining eligible for insurance under the Policy unless such changes have been approved by Our authorized representative in Our home office.

First Enrollment Period means the 60-day period following the day the Member becomes eligible for insurance under the Policy or any Prior Plan.

Life Event means:

a) a change in Your legal marital status or partnership;
b) a change in the number of Your Dependents; or
c) a significant cost or coverage change under any other employer or group sponsored disability plan under which You are covered.

Prior Plan means any policy or plan of benefits:

a) replaced by insurance under part or all of the Policy; and
b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

Subsequent Enrollment Period means any period of up to 60 consecutive calendar days designated for enrollment under the Policy by the Policyholder or Benefits Administrator and agreed to in writing by Our authorized representative in Our home office.

Written Request means a request that is signed, dated and submitted to the Policyholder, Benefits Administrator or Us. The request must be on a form We supply or be in a form and content acceptable to Us.

WHEN A MEMBER BECOMES ELIGIBLE FOR INSURANCE

A Member who is Actively Eligible on the Policy Effective Date becomes eligible for insurance under the Policy on the Policy Effective Date.

An individual that becomes a Member after the Policy Effective Date becomes eligible for insurance under the Policy on the day the Member begins Active Eligibility.

The day on which a Member becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

EFFECT OF A PRE-EXISTING CONDITION WITH PRIOR COVERAGE

Prior Group Disability Plan Coverage Maintained by the Policyholder

If You become insured under the Policy on the Policy Effective Date and were covered under a Prior Plan on the day before the Policy Effective Date, any benefits payable under the Policy for a Disability due to a Pre-existing Condition will be determined as follows:

a) If You cannot satisfy the Pre-existing Conditions provision of the Policy, but have satisfied the pre-existing condition provision under the Prior Plan, giving consideration towards continuous time covered under both plans, We will pay the lesser of the benefit:
    1. that would have been paid under the Prior Plan; or
    2. payable under the Policy.
b) If You cannot satisfy the Pre-existing Conditions provision under the Policy or of the Prior Plan, no benefit under the Policy will be payable.

Prior Group Disability Plan Coverage Not Maintained by the Policyholder

If You become insured under the Policy after the Policy Effective Date and were covered under an employer's group long-term disability plan provided by Your previous employer, and not maintained by the Policyholder, within 60 days prior to the day you become insured under the Policy, any benefits payable under the Policy for a Disability due to a Pre-existing Condition will be determined as follows:

a) If You cannot satisfy the Pre-existing Conditions provision of the Policy, but have satisfied the pre-existing condition provision under Your prior group disability plan, giving consideration towards continuous time covered under both plans, We will pay the lesser of the benefit:
    1. that would have been paid under Your prior group long-term disability plan; or
    2. payable under the Policy.
b) If You cannot satisfy the Pre-existing Conditions provision under the Policy or Your prior group long-term disability plan, no benefit under the Policy will be payable.

In order to qualify under this provision, You must provide the following supporting documentation within 31 days from the date We request this information:

a) a copy of Your prior employer's long-term disability plan; and
b) payroll records or other documentation verifying prior group long-term disability coverage under Your prior employer's plan.

WHEN INSURANCE BEGINS

An eligible Member must enroll for insurance by submitting a Written Request for insurance. The Written Request must be submitted to the Policyholder or Benefits Administrator within 60 days following the day the Member becomes eligible. If the Written Request for insurance is not submitted within 60 days following the day the Member becomes eligible for insurance, We will require Evidence of Insurability.

An eligible Member will become insured, subject to payment of required premiums, on the first day of the month that coincides with or follows the latest of the day:

a) the Member begins Active Eligibility; or
b) the Member submits a Written Request to enroll for insurance, if applicable; or
c) We approve Evidence of Insurability, if required.

An eligible Member will become insured, subject to payment of required premiums, for an amount of insurance in excess of the Guarantee Issue Amount on the first day of the month that coincides with or follows the day We approve Evidence of Insurability.

EXCEPTIONS TO WHEN INSURANCE BEGINS

Insurance for a Member who is:

a) confined in a Hospital as an inpatient;
b) confined in any institution or facility other than a Hospital; or
c) confined at home and under the care or supervision of a Physician;

on the day insurance is to begin will not take effect until the first day of the month that coincides with or follows the day after the Member is no longer confined.

THE FIRST ENROLLMENT PERIOD

A Member may elect insurance for him/herself during the Member's First Enrollment Period.

If a Member does not elect insurance during the Member's First Enrollment Period, future elections may only be made in accordance with the Subsequent Enrollment Periods provision, or as otherwise provided under the When Election Changes Are Permitted provision.

SUBSEQUENT ENROLLMENT PERIODS

A Member may elect, drop, increase, decrease or change insurance during a Subsequent Enrollment Period.

WHEN ELECTION CHANGES ARE PERMITTED

A Member may elect, drop, increase, decrease or change insurance as allowed by the Policyholder or Benefits Administrator. Any election of or increase in insurance for a Member will require Evidence of Insurability unless otherwise stated or allowed in the Policy. Any election of or increase in insurance is subject to the Pre-existing Conditions provision of the Policy as of the effective date of the increase.

Life Events

Within 60 days of a Life Event, You may submit a Written Request to change insurance.

If You experience a Life Event and You are currently insured under the Policy, insurance for You may be issued up to the Guarantee Issue Amount without Evidence of Insurability. For any amount of insurance over the Guarantee Issue Amount, or if the Written Request is submitted more than 60 days after the date of a Life Event, We will require Evidence of Insurability.

A Member who experiences a Life Event who previously declined insurance under the Policy must submit Evidence of Insurability for any change of insurance to be considered by Us.

CHANGES TO INSURANCE BENEFITS

Any allowable change in Your class or amount of insurance, whether requested by You or the Policyholder or Benefits Administrator, or as a result of the terms of the Policy, will take effect on the first day of the month that coincides with or follows the date of the request or the change, or the first day of the month that coincides with or follows the day We approve Evidence of Insurability (if required by Us), whichever is later.

For any increase in insurance, We will use the Policyholder or Benefit Administrator's records and/or the premium We have received to verify that the amount of insurance being requested is the appropriate insurance amount for which the Insured Person is eligible under the terms of the Policy.

If You are not Actively Eligible on the day any increase in insurance would otherwise take effect, the increase will become effective the first day of the month that follows the day after You return to Active Eligibility.

In no event will any change take effect during a period of Disability.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended for You in accordance with this provision. You must submit a Written Request to reinstate insurance within 60 days of Your return to Active Eligibility. We will require Evidence of Insurability if the amount of insurance being requested exceeds the amount of insurance in effect on the Member's last day of Active Eligibility.

Reinstated insurance will take effect on the first day of the month that coincides with or follows the dateof the Written Request, or the first day of the month that coincides with or follows the day We approve Evidence of Insurability (if required by Us), whichever is later. If You are not Actively Eligible on the day the reinstated insurance would otherwise take effect, insurance will become effective on the first day of the month that coincides with or follows the day after You return to Active Eligibility.

The following reinstatement option(s) is/are available:

Non-Payment of Premium or Voluntary Termination of Insurance

If insurance ended due to Your non-payment of premium or voluntary termination of insurance, We will require Evidence of Insurability to reinstate insurance if Your Written Request is not submitted within the 60 day period.

WHEN INSURANCE ENDS

Insurance will end on the last day of the month in which the earliest of the following events occurs:

a) You are no longer eligible for insurance under the Policy;
b) You reach the age of 65; or
c) You begin active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 60 days or less).

Insurance will also end:

a) on the day the Policy terminates; or
b) in accordance with the Grace Period provision.

If You are Disabled on the day the Policy terminates, benefits will continue subject to the When Benefits End provision located in the Benefits section.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for You would otherwise end but the Policy is in effect, You may be able to continue insurance under the Continuation of Insurance During Disability provision.

CONTINUATION OF INSURANCE DURING DISABILITY

If You become Disabled, Your insurance will continue without payment of premium for as long as You are entitled to receive Monthly Benefits, except that premium must be paid during the Elimination Period. Any premium for Your insurance that is payable by You will be waived from the first day of the month following the end of the Elimination Period through the last day of the month in which Your last Disability benefit payment under the Policy is issued.

PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

GRACE PERIOD

All premiums must be paid within the grace period. There is a grace period of 31 days for payment of premiums. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 31-day period that follows. We will consider premium to be paid on the date the Benefits Administrator receives it.

Insurance will stay in force during the grace period, unless You, the Policyholder or Benefits Administrator provide Us with written notice that insurance will terminate during the grace period. If We receive such notice, insurance will terminate on the date requested.

If any premium due is not paid during the grace period, insurance for You will end on the last day of the grace period. If insurance ends, it may be reinstated as described in the Reinstatement of Insurance provision.

PREMIUM CHANGES

If You request a change in the amount of insurance, the Policyholder or Benefits Administrator will provide You with notice of Your new premium amount upon request if You are responsible for the payment of premiums for insurance.

If there is a change in the amount of the premium for insurance in accordance with the terms of the Policy, or a change in the amount of insurance as the result of a request of the Policyholder or Benefits Administrator, the Policyholder or Benefits Administrator will provide You with notice of the change at least 15 days prior to the date of the change if You are responsible for the payment of premiums for insurance.

Premium amounts will change if:

a) You reach the Attained Age of the next higher age band in the premium rate structure for the Policy; or
b) premium rates under the Policy are changed.

LONG-TERM DISABILITY BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Good Cause means documented physical or mental impairments that:

a) render You incapable of rehabilitation;
b) interfere with a medical program You are currently participating in; or
c) conflict with any other program You are participating in that will enable You to return to active employment.

Participation in a Riot means actively participating in a tumultuous disturbance of the peace by three or more persons assembling together of their own authority with intent to mutually assist one another in an illegal or legal act.

LONG-TERM DISABILITY BENEFITS

If You become Disabled due to an Injury or Sickness while insured under the Policy, We will pay the Monthly Benefit shown in the Schedule in accordance with the terms of the Policy. Benefits will begin after You satisfy the Elimination Period shown in the Schedule.

SURVIVOR BENEFIT

This provision applies to residents of all states except Michigan and North Carolina.

We will pay a Survivor Benefit to Your Eligible Survivor when We receive proof that You died:

a) after being Disabled; and
b) while receiving or eligible to receive a Monthly Benefit under the Policy.

The Survivor Benefit will be payable as a lump sum amount equal to three times Your Monthly Benefit for the month immediately prior to Your death.

If a Survivor Benefit is payable to Your Dependent Child and, if there is more than one such Dependent Child, then the Survivor Benefit will be divided equally among such Dependent Children.

If payment becomes due to Your Dependent Child or Dependent Children, the payment will be made to:

a) Your Dependent Child; or
b) a person legally authorized to receive payments or the Dependent Child's or Dependent Children's behalf. This payment will be valid and effective against all claims by the Dependent Child or Dependent Children or by others representing or claiming to represent such Dependent Child or Dependent Children.

If there are no Eligible Survivors, the Survivor Benefit will be paid to Your estate.

Any payment made in good faith will fully discharge Us to the extent of the payment.

SURVIVOR BENEFIT

This provision applies to residents of the states of Michigan and North Carolina.

We will pay a Survivor Benefit to Your named beneficiary when We receive proof that You died:

a) after being Disabled; and
b) while receiving or eligible to receive a Monthly Benefit under the Policy.

The Survivor Benefit will be payable as a lump sum amount equal to three times Your Monthly Benefit for the month immediately prior to Your death.

You have the right to change Your beneficiary designation. The consent of the beneficiary or beneficiaries is not necessary for any change in beneficiary. If You have not designated a beneficiary, or no beneficiary survives You, the survivor benefit will be paid to Your estate.

Any payment made in good faith will fully discharge Us to the extent of the payment.

VOCATIONAL REHABILITATION PROVISION

If You are Disabled and are receiving Disability benefits as provided by the Policy, You may be eligible to receive vocational rehabilitation services. These services include, but are not limited to:

a) worksite modification and/or special equipment;
b) job placement;
c) r etraining; and
d) other services reasonably necessary to help You return to work.

While You are participating in a plan of vocational rehabilitation approved by Us, Your Monthly Benefit will be increased by a percentage as shown in the Schedule.

Eligibility for vocational rehabilitation services is based on Your education, training, experience and physical/mental capabilities. Before vocational rehabilitation services will be considered:

a) Your Disability must not allow You to perform Your Regular Occupation;
b) You must have the physical and mental capability to complete a rehabilitation program; and
c) there must be reasonable expectation that rehabilitation services will help You return to active employment.

We will develop an Individual Written Rehabilitation Plan (IWRP), which may include input from You, Your Physician and the Policyholder or Benefits Administrator. The IWRP will describe:

a) the vocational rehabilitation goals and services;
b) the responsibilities of Us, You and any third parties associated with the IWRP;
c) the times and dates of the vocational rehabilitation services; and
d) all costs associated with the services.

Either We, Your Physician or You may initiate consideration for Your participation in vocational rehabilitation. Failure to participate without Good Cause will result in reduction or termination of Disability benefits. Reduction of benefits will be based on Your income potential if You were employed after a vocational rehabilitation program.

We will make the final determination of any vocational rehabilitation services provided, eligibility for participation and any continued benefit payments.

While You are a participant in an IWRP, Monthly Benefits will continue to be payable subject to reduction by Other Income Sources. Eligibility for continued Monthly Benefits will be assessed at the completion of the IWRP.

WHEN DISABILITY BENEFITS END

Benefits will be paid during a period of Disability until the earliest of the day:

a) You are no longer Disabled;
b) Yo u die;
c) on which the Maximum Benefit Period ends as shown in the Schedule;
d) You fail to provide Us satisfactory proof of continuous Disability;
e) You fail to provide Us satisfactory Proof of Earnings;
f) You have been incarcerated or imprisoned for 31 days or longer;
g) You fail to comply with Our request to be examined by a Physician and/or vocational rehabilitation expert of Our choice;
h) You are not under Regular and Appropriate Care and Treatment for the Injury or Sickness that caused the Disability;
i) You are able to return to work with the Policyholder or any other employer on a part-time or Full-Time basis and do not do so; or
j) We have paid You 12 Monthly Benefit payments, if You reside outside the U.S., its territories or possessions. You will be considered to reside outside the U.S., its territories or possessions if You have been outside the U.S., its territories or possessions for a total of six months or more during any twelve consecutive month period during which You were continuously Disabled.

If You are eligible to receive Disability payments on the day the Policy ends, benefits will continue subject to all other Policy provisions.

PRE-EXISTING CONDITION EXCLUSION

A Pre-existing Condition means any Injury or Sickness for which You received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 12 months prior to the day You become insured under the Policy.

We will not provide benefits for any Disability caused by, attributable to, or resulting from a Pre-existing Condition which begins in the first 24 months after You are continuously insured under the Policy.

EXCLUSIONS

We will not pay benefits for any Disability or loss which:

a) for residents of all states except Oklahoma and Washington, results from an act of declared or undeclared war or armed aggression;
b) for residents of the state of Oklahoma, results from an act of declared or undeclared war or when serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer;
c) for residents of the state of Washington, results from an act of declared or undeclared war;
d) results from Your Participation in a Riot or Your commission of or attempt to commit a felony or any type of assault or battery;
e) , results, whether You are sane or insane, from:
   1. an intentionally self-inflicted Injury or Sickness; or
   2. atte mpted suicide;
f) is caused by Alcohol and Drug Abuse and/or Substance Abuse, while You are not being actively supervised by and receiving continuing treatment from a rehabilitation center or designated institution approved for such treatment by an appropriate body in the governing jurisdiction, or if none, by Us;
g) occurs while You are incarcerated or imprisoned for any period exceeding 31 days; or
h) is solely a result of a loss of a professional license, occupational license, or certification.

PAYMENT OF CLAIMS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

HOW TO OBTAIN PLAN BENEFITS FOR DISABILITY OR OTHER LOSS

Forward the completed claim form for Disability or other benefits to:
Benefits Administrator
Wells Fargo Insurance Services USA
648 Monroe Ave NW
Suite 300
Grand Rapids, MI 49503-1453
Phone: 1-800-254-2327

You will be responsible for any fees charged by Your Physician for completing a claim form.

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
United of Omaha Life Insurance Company
Group Disability Management Services
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-877-5176

PROOF OF DISABILITY

A claim form can be requested from the Benefits Administrator, from Us or obtained on Our website. A request for a claim form should be made within 20 days after a Disability occurs or as soon as reasonably possible. If You do not receive a claim form within 15 days of Your request, You can provide a written statement to Us, stating:

a) that You are under the Regular and Appropriate Care and Treatment of a Physician;
b) the appropriate documentation of Your job duties at Your Regular Occupation and Your Basic Monthly Earnings;
c) the date Your Disability began;
d) the cause of Your Disability;
e) any restrictions and limitations preventing You from performing Your Regular Occupation; and
f) the name and address of any attending Physician, Hospital or institution where You received treatment.

A completed claim form and other information needed to prove loss must be submitted to Us within 90 days after the end of the Elimination Period.

Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

a) it was not reasonably possible to give proof within that 90-day period; and
b) proof is furnished as soon as reasonably possible, but not later than one year after the end of the Elimination Period, unless You or Your beneficiary are not legally capable.

Proof of continued Disability, Regular and Appropriate Care and Treatment of a Physician and any Other Income Sources must be given to Us, upon request. This proof must be received within 45 days of Our request. If it is not, benefits may be denied or suspended.

ADDITIONAL SUPPORTING INFORMATION FOR DISABILITY AND OTHER CLAIMS

We may occasionally require You to be examined by a Physician or vocational rehabilitation expert of Our choice to assist in determining whether benefits are payable. We will pay for these examinations; however, You may be responsible for fees associated with failure to notify the examination office of Your appointment cancellation within the required amount of time specified by the examiner. We may recover this fee by reduction of benefits that are payable. We will not require more than a reasonable number of examinations.

Disability and other benefits will be paid after We receive acceptable proof of loss. Benefits will be paid only if We determine that the claimant is entitled to benefits under the terms of the Policy. We may require supporting information which may include, but is not limited to, the following:

a) clinical records;
b) charts;
c) x-rays;
d) Proof of Earnings; and
e) other diagnostic aids.

MODE OF PAYMENT FOR DISABILITY

Disability benefits will be paid by Us monthly after We receive acceptable proof of Disability. Benefits will be paid to You, except benefits unpaid at Your death may be paid, at Our option, to:

a) Your Eligible Survivor; or
b) Your estate.

REFUND TO US

This provision does not apply to residents of the states of Kansas, Nebraska or Tennessee.

If it is found that We paid more benefits than We should have paid under the Policy, We have the right to a refund from You or the recipient of benefits.

We also have a right to a refund for any payments due to:

a) fraud or misrepresentation;
b) any error We make in processing a claim; or
c) Your receipt of Other Income Sources.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made, including without limitation, reducing or withholding Your Monthly Benefit or any benefits payable to You under any other disability insurance policy issued by Us. We will credit these payments to the refund until the refund is fully recovered.

REFUND TO US

This provision applies to residents of the state of Nebraska.

We have the right to a refund from You or the recipient of benefits of any overpayment of benefits under the Policy, including, without limitation, any overpayment due to:

a) fraud or misrepresentation;
b) any error We make in processing a claim; or
c) Your receipt of Other Income Sources.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made, including without limitation, reducing or withholding Your Monthly Benefit or any benefits payable to You under any other disability insurance policy issued by Us. We will credit these payments to the refund until the refund is fully recovered.

We will not withhold any portion of Your Monthly Benefit or any benefits payable under the Policy unless we have in Our files:

a) clear, documented evidence of the overpayment and written authorization from You permitting such withholding procedure; or
b) clear, documented evidence that:
    1. the overpayment was clearly erroneous under the provisions of the Policy and is not the subject of a reasonable dispute of facts;
    2. the error which resulted in the overpayment is not a mistake of law;
    3. We notified You or the recipient of benefits within six months of the date of the error, except that in instances of error prompted by representations or nondisclosures of You or the recipient of benefits, We notified You or

the recipient of benefits within 15 days after the date that clear, documented evidence of discovery of such error is included in Our file; and

4. such notice states clearly the nature of the error, the amount of the overpayment, and that the claim used to correct the first overpayment is made within 3 years after the date of the error.

REFUND TO US

This provision applies to residents of the state of Tennessee.

If it is found that We paid more benefits than We should have paid under the Policy, We have the right to a refund from You or the recipient of benefits within 18 months from the date of the payment.

This 18-month time limit does not apply to a refund for any payments due to:

a) fraud or misrepresentation;
b) Your failure to provide complete information; or
c) You not being eligible for coverage.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made, including without limitation, reducing or withholding Your Monthly Benefit or any benefits payable to You under any other disability insurance policy issued by Us. We will credit these payments to the refund until the refund is fully recovered.

ERRORS RELATED TO YOUR COVERAGE

This provision applies to residents of the state of Kansas.

We have the right to correct benefit payments that are made in error.

If it is found that We paid more benefits than We should have paid under the Policy, We have a right to a refund from You or the recipient of benefits. You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made, including without limitation, reducing or withholding Your Monthly Benefit or any benefits payable to You under any other disability insurance policy issued by Us. We will credit these payments to the refund until the refund is fully recovered.

If it is found that We paid less benefits than We should have paid under the Policy, We will make additional payments, including, without limitation, increasing Your Monthly Benefit.

NOTICE OF COMPLAINT AND APPEAL PROCEDURE

This form applies only to residents of the state of Michigan.

We have established and will maintain procedures for hearing, researching, recording, and resolving any complaints an Insured Person may have. These procedures are intended to ensure full investigation of a complaint and provide timely notification as to the progress of Our investigation.

An Insured Person has the right to contact the Michigan Office of Financial and Insurance Regulation for review and determination of a Grievance at any time.

For inquiries and/or complaints, please call the toll-free number on Your identification card. We must receive the Insured Person's complaint as soon as reasonably possible following the date of the incident or discovery that forms the basis for the Grievance. The request must be in writing.

A written complaint may be sent to the following address:

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175

We will inform the Insured Person within 45 days after We receive the written appeal or complaint, unless an unusual circumstance requires an extension of time to investigate or consider. If this occurs, We will inform the Insured Person of the reason the additional time is needed; not to exceed another 45 days, unless the initial period is extended due to the Insured Person's failure to submit information necessary to decide the claim on appeal. If the extension is due to the Insured Person's failure to submit information, the period for making the determination will be deferred until the date the Insured Person responds to the request for additional information.

The following steps will be used to resolve any complaint We receive.

REVIEW PROCESS

If possible, We will resolve the Grievance through a review of medical records and all relevant information. We will notify the Insured Person in writing of Our findings within 60 days of Our receiving the Grievance.

If the review does not resolve the Grievance to the Insured Person's satisfaction, the Insured Person may request the Adverse Determination be reconsidered by the Manager/Review Committee. This request must be sent within 30 days of Our notifying the Insured Person of the informal review findings. The Manager/Review Committee will notify the Insured Person in writing of its findings within 30 days of receiving the request for a formal review; unless We notify the Insured Person that an additional 30 days will be required.

If the review process does not resolve the Grievance to the Insured Person's satisfaction, the Insured Person may appeal to the Michigan Office of Financial and Insurance Regulation for review.

EXPEDITED GRIEVANCE PROCEDURES

An "expedited Grievance" applies if a Grievance is submitted and a Physician, orally or in writing, substantiates that the time frame for a Grievance would actually jeopardize the life of the Insured Person. We will make a determination no later than 72 hours following the receipt of an expedited Grievance.

Within three business days after Our initial determination, the Insured Person, or a person, including the Physician (authorized in writing to act on behalf of the Insured Person) may request further review by Us or for a determination of the matter by the Michigan Insurance Commissioner or his or her designee. If further review is requested, a final determination will be made no later than 30 days after Our receipt of the request for further review.

Within 10 days after receipt of a final determination, the Insured Person, a person authorized by the Insured Person, or a Physician (authorized in writing by Us) may request a determination of the matter by the Michigan Insurance Commissioner. If the initial or final determination is made orally, We will provide written confirmation to the Insured Person no later than two business days after the oral determination.

An expedited external review will not be provided for retrospective Adverse Determinations or retrospective final Adverse Determinations.

The address for the Michigan Office of Financial and Insurance Regulation is:

Health Plans Division
P. O. Box 30220
Lansing, Michigan 48909
(877) 999-6442

EXTERNAL APPEAL PROCEDURES

If We have not issued a written decision to the Insured Person or his or her authorized representative within the required time and without the Insured Person or his or her authorized representative requesting or agreeing to a delay, the Insured Person or his or her authorized representative may file a request for external review and will be considered to have exhausted Our internal Grievance process.

The Insured Person or his or her authorized representative has the opportunity to submit additional information during the external appeal process. All requests for external review must be made in writing to the Commissioner. Not later than 60 days after the date of receipt of a notice of an Adverse Determination or final Adverse Determination, the Insured Person or his or her authorized representative may file a request for an external review with the Commissioner.

The Commissioner has five business days to conduct a preliminary review of the request and determine the following:

a) Whether the Insured Person was covered by the health benefit plan when the health care service was provided;
b) Whether the Insured Person has exhausted Our internal Grievance process unless the Insured Person is not required to exhaust Our internal Grievance process;
c) The Insured Person has provided all the information and forms required by the Commissioner that are necessary to process an external review, including the health information release form.

The results of the preliminary review will be communicated, in plain English writing, to the Insured Person and, if applicable, his or her authorized representative. If a request for an external review is not accepted by the Commissioner, the Commissioner will inform the relevant parties of the information or materials needed to make the request complete, or the reasons the request was declined.

If a request is accepted for external review, the Commissioner will do the following:

a) Include a statement that the Insured Person or his or her authorized representative may submit to the Commissioner in writing within 7 days following the date of receipt of the notice additional information and supporting documentation that the assigned Independent Review Organization will consider when conducting the external review.
b) Immediately notify Us in writing of the acceptance of the request for external review.
c) Assign an approved Independent Review Organization to conduct the external review and to provide a written recommendation to the Commissioner on whether to uphold or reverse the Adverse Determination or the final Adverse Determination.

We will respond to the Independent Review Organization no later than seven business days from Our receipt of the notice from the Commissioner and provide the documents and any information considered in making the Adverse Determination or the final Adverse Determination. If the pertinent information is not sent to the Independent Review Organization within that time frame, the Independent Review Organization may notify the Commissioner of this failure and the Commissioner will then close the external review and render a decision to reverse Our decision. Such a determination is to be communicated to the interested parties immediately. The Independent Review Organization will provide its recommendation to the Commissioner no later than 14 days after acceptance by the Commissioner of the request for an external review. Within the next seven business days the Commissioner will notify the parties of the decision.

An external review decision and an expedited external review decision are the final administrative remedies available.

We may seek other remedies available under applicable state law. An Insured Person may seek other remedies available under applicable federal or state law. An Insured Person or his or her authorized representative may not file a subsequent request for external review involving the same Adverse Determination or final Adverse Determination for which the Insured Person has already received an external review decision under this provision.

Copies of all documents will be available for review by the Commissioner of Insurance for two years following the year the Grievance was filed.

DEFINITIONS

Adverse Determination means a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

Grievance means a complaint on behalf of an Insured Person submitted by an Insured Person or another person, including, but not limited to, a Physician, authorized in writing to act on behalf of the Insured Person regarding:

a) the availability, delivery, or quality of health care services, including a complaint regarding an Adverse Determination made pursuant to utilization review;
b) benefits or claim payment, handling, or reimbursement for health care services; or
c) matters pertaining to the contractual relationship between the Insured Person and Us.

Independent Review Organization means an entity that conducts independent external reviews of Adverse Determinations.

NOTE: A WRITTEN NOTIFICATION OF THESE GRIEVANCE PROCEDURES WILL BE PROVIDED TO ANY INSURED PERSON UPON APPEAL OF AN ADVERSE DETERMINATION.

CLAIM REVIEW AND APPEAL PROCEDURES

This form applies to residents of all states except Michigan. Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

IMPORTANT NOTICE: In addition to the requirements described in this document, applicable state laws may contain requirements for claims review and appeal procedures. To the extent that any requirement in this document is inconsistent with any state law requirement, the requirement that is most favorable to the person insured under the Policy shall prevail. If You have any questions, please contact Us.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, any such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

Claimant means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except where the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) Initial claim decision period: 45 days unless additional information is requested as set forth below;
b) Extension period: 30 days; and
c) Maximum number of extensions: Two.

If additional information is needed, We will notify the Claimant within 10 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 45 days to submit the additional information to Us. We will make Our determination within 15 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 180 days and the right to bring a civil action following the appeal process; and
d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

OPPORTUNITY TO REQUEST AN APPEAL

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 180 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

a) the Insured Person's name;
b) the name of the person filing the appeal if different from the Claimant;
c) the Policy number; and
d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

RESPONSE TO APPEALS

We will respond no later than 45 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 45 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

a) information regarding the decision; and
b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

INSURANCE CONTRACT

The insurance contract consists of:

a) th e Policy;
b) the Policyholder's signed application attached to the Policy; and
c) any application signed by You.

For residents of all states except New York, statements in an application are considered representations and not warranties. We will not use any statements in an Insured Person's application to deny a claim or to contest the validity of this insurance unless We provide You, Your beneficiary or Your authorized representative with a copy of that application.

For residents of the state of New York, statements made by, or by the authority of the applicant for the issuance, reinstatement or renewal of the Policy, are considered representations and not warranties. The rights of the Policyholder, an Insured Person or beneficiary shall not be affected by any provisions not contained:

a) in the Policy, riders, endorsements or amendments signed by the Policyholder and Us;
b) in the Policyholder's application attached to the Policy; or
c) in any individual statement submitted with the application.

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require the consent of any Insured Person or beneficiary; and
b) m ust be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by Our authorized representative in Our home office.

A change may affect any class of Insured Persons included in the Policy.

INCONTESTABILITY

For residents of the state of Montana, we will not contest this Policy after it has been in force two years, except for nonpayment of premium.

For residents of all states except New York, we will not use any statements in an Insured Person's application to contest the validity of this insurance after it has been in-force during the lifetime of the Insured Person for two years.

For residents of the state of New York, the Policy is incontestable after two years from its date of issue, except for non-payment of premiums by the Policyholder or Member. No statement made by an Insured Person relating to insurability may be used in contesting the validity of insurance with respect to which such statement was made after such insurance has been in force for a period of two years during the Insured Person's lifetime and in no event unless in a written instrument signed by the Insured Person, a copy of which is or has been furnished to the Insured Person or beneficiary. Any contest of the validity of this insurance will be based on material misrepresentations in the related application.

LEGAL ACTIONS

This provision does not apply to the residents of the states of New Jersey and New York.

No legal action can be brought until at least 60 days after We have been given written proof of loss. No legal action can be brought more than six years after the date written proof of loss is required, unless otherwise required by state law in Your state of residence.

MISSTATEMENT OF AGE OR GENDER

This provision only applies to residents of the state of New York.

If an Insured Person's age or gender is misstated, We may adjust the premium or the benefits payable. An adjustment of the benefits payable will be based on what the premium would have purchased at the correct age or gender.

MISSTATEMENT OF AGE

This provision only applies to residents of the state of Montana.

If an Insured Person's age is misstated, We may adjust the premium or the benefits payable. An adjustment of the benefits payable will be based on what the premium would have purchased at the correct age.

GENERAL DEFINITIONS

The following capitalized terms have the meanings assigned in this section. These terms are used throughout the Policy. The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Active Independent Business Owner (IBO) Engaged in Non-Preferred Industry(ies) means someone who is:

a) an active member of the Policyholder on the date We receive any Written Request or application for insurance;
b) still currently an active member of the Policyholder; and
c) engaged in one or more Non-Preferred Industries.

Active Independent Business Owner (IBO) Not Engaged in Non-Preferred Industry(ies) means someone who is:

a) an active member of the Policyholder on the date We receive any Written Request or application for insurance;
b) still currently an active member of the Policyholder; and
c) not engaged in any Non-Preferred Industry(ies).

Attained Age means the age of the Insured Person as of the first day of the month that coincides with or follows the date of the first day of the billing period that follows the Insured Person's birthday. For example, if an Insured Person's 50th birthday is on July 3, 2012, and the Insured Person has a quarterly billing mode that runs from June through August, the Insured Person will reach the attained age of 50 on September 1, 2012 (the first day of the billing period that follows the birthday).

Benefits Administrator or Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group disability insurance plan.

Certificate means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

Current Earnings means any actual pre-tax monthly income You receive while You are working and eligible to receive a Monthly Benefit, or the pre-tax earnings You could receive if You were working at Your Maximum Capacity. If Your current earnings fluctuate, We may average Your current earnings over the most recent three-month period and continue Your claim provided the average does not exceed the percentage of Basic Monthly Earnings allowed by the Policy. A Monthly Benefit will not be payable for any month during which Your current earnings exceed that percentage.

Dependent Child means:

a) Your natural born or legally adopted child;
b) Your stepchild or child of Your domestic or civil union partner or equivalent living in Your home; or
c) any other child who lives with You and:
    1. for residents of all states except New York, is in a regular parent/child relationship and who qualifies as Your "dependent" as defined in the United States Internal Revenue Code; or
    2. for residents of the state of New York, is dependent on You for support and maintenance.

Dependent child does not include:

a) a child who is married, in a domestic partnership, in a civil union partnership, or equivalent as recognized and allowed by federal law, or by state law in a child's state of residence;
b) a child who has been legally adopted by another person; or
c) a child:
    1. temporarily living in Your home;
    2. placed in Your home by a social service agency which retains control over the child; or
    3. who has a natural parent in a position to exercise parental responsibility and control.

Disability and *Disabled* mean that because of an Injury or Sickness, a significant change in Your mental or physical functional capacity has occurred in which You satisfy either the Occupation Test or the Earnings Test. You need to satisfy only one test in order to be considered disabled.

Occupation Test means:

a) during the Elimination Period, You are prevented from performing the Material Duties of Your Regular Occupation; and
b) after the Elimination Period, You are unable to perform at least one of the Material Duties of Your Regular Occupation.

Earnings Test means You are unable to generate Current Earnings which exceed 80% of Your Basic Monthly Earnings in Your Regular Occupation.

Eligible Survivor means Your Spouse, if living; otherwise, it means Your Dependent Child under age 26. An eligible survivor must be living at the time of Your death.

Evidence of Insurability means proof of good health acceptable to Us. This proof may be obtained through questionnaires, physical exams or written documentation, as required by Us.

Full-Time means working the required number of hours to be considered a full-time employee of the Policyholder or any other employer.

Guarantee Issue Amount means the amount of disability insurance We may issue without requiring Evidence of Insurability.

Hospital means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Injury means an accidental bodily injury that requires treatment by a Physician. For residents of all states except Illinois, it must result in loss independently of Sickness and other causes. Disability resulting from an injury must occur while You are insured under the Policy.

Material Duties means the essential tasks, functions, and operations relating to an occupation that cannot be reasonably omitted or modified. In no event will We consider working an average of more than the required Full-Time hours per week in itself to be a part of material duties.

Maximum Capacity means, based on Your medical restrictions and limitations, the greatest extent of work You are able to do in Your Regular Occupation.

Maximum Monthly Benefit means the maximum dollar amount of disability benefit You may receive per month as shown in the Schedule.

Medically Necessary means care that is ordered, prescribed, or rendered by a Physician or Hospital, and is determined by Us, or a qualified party or entity selected by Us, to be:

a) provided for the diagnosis or direct treatment of Your Injury or Sickness;
b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of Your Injury or Sickness; and
c) provided in accordance with generally accepted national professional standards and/or medical practice.

Member means a person who is:

a) under age 60 on the day insurance begins under the Policy; and
b) a citizen or permanent resident of the United States; or
c) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
d) performing all the regular duties of an occupation for wage or profit on a Full-Time basis and for at least 30 hours per week; and
e) one of the following:
    1. an Active Independent Business Owner (IBO) Not Engaged in Non-Preferred Industry(ies);
    2. a Non-Independent Business Owner (IBO) Not Engaged in Non-Preferred Industry(ies);
    3. an Active Independent Business Owner (IBO) Engaged in Non-Preferred Industry(ies); or
    4. a Non-Independent Business Owner (IBO) Engaged in Non-Preferred Industry(ies).

A member does not include a person who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office.

Monthly Benefit means the amount of disability benefit You may receive per month as described in the Schedule.

Non-Independent Business Owner (IBO) Engaged in Non-Preferred Industry(ies) means someone who:

a) was an active member of the Policyholder on the date We or the Prior Plan received any Written Request or application for insurance;
b) is no longer an active member of the Policyholder; and
c) is engaged in one or more Non-Preferred Industries.

Non-Independent Business Owner (IBO) Not Engaged in Non-Preferred Industry(ies) means someone who:

a) was an active member of the Policyholder on the date We or the Prior Plan received any Written Request or application for insurance;
b) is no longer an active member of the Policyholder; and
c) not engaged in any Non-Preferred Industry(ies).

Non-Preferred Industry, Non-Preferred Industries means commercial fishing; hunting and trapping; coal mining; wrecking and demolition; oil and gas field service; steeple-jacking; antenna installation; ammunition; taxicab driver; sanitation; deep sea freight; commercial and non-commercial pilots; refuse and sanitary systems (sewage); scrap and waste materials; auto processing; bail bondsman; professional sport racing; amusement materials; justices; public order and safety (police, fire and ambulance); military personnel; asbestos; logging and saw mills; flight instructors; and nuclear energy.

Our, We, Us means United of Omaha Life Insurance Company.

Physician means any of the following licensed practitioners:

a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
b) a licensed doctoral clinical psychologist;
c) a Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
d) a licensed physician's assistant (PA) or nurse practitioner (NP); or
e) where required by law, any other licensed practitioner of a healing art who is acting within the scope of his/her license.

A physician does not include:

a) a naturopathic doctor;
b) an acupuncturist;
c) a physician in training; or
d) You, Your Spouse or a child, brother, sister or parent of You or Your Spouse or any person who lives with You.

Policy means the group policy issued to the Policyholder by Us, including this Certificate.

Policy Anniversary means April 1 of each Policy Year.

Policy Effective Date means April 1, 2012.

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

Proof of Earnings means:

a) copies of Your U.S. individual income tax returns and business income tax returns, including all forms, schedules and attachments, if applicable;
b) payroll records; and
c) any other records We request.

Regular and Appropriate Care and Treatment means You visit and receive care and treatment from a Physician as frequently as is medically required, to effectively manage and treat Your Injury or Sickness. Such care and treatment must be:

a) Medically Necessary;
b) received from a Physician whose expertise, medical training, and clinical experience are suitable for treating Your Injury or Sickness; and
c) received primarily is to improve Your medical condition and thereby aid in Your ability to return to work.

Regular Occupation means the occupation You are routinely performing when Your Disability begins. Your regular occupation is not limited to Your specific position held with the Policyholder, but will instead be considered to be a similar position or activity based on job descriptions included in the most current edition of the U.S. Department of Labor Dictionary of Occupational Titles (DOT). We have the right to substitute or replace the DOT with another service or other information that We determine to be of comparable purpose, with or without notice. To determine Your regular occupation, We will look at Your occupation as it is normally performed in the national economy, instead of how work tasks are performed for a specific employer, at a specific location, or in a specific area or region.

Retirement Plan means a plan which:

a) provides benefits to You, either in a lump sum or in the form of periodic payments, upon the later of:
    1. early or normal retirement as defined in the plan or under the U.S. Social Security Act; or
    2. disability, if the payment does not reduce the amount of money which would have been paid at the normal retirement age under the plan if the disability had not occurred; and
b) is not funded wholly by Your contributions.

Schedule means the section of the Certificate identified as the "Schedule".

Sickness means a disease, disorder or condition, including pregnancy, that requires treatment by a Physician. Disability resulting from a sickness must occur while You are insured under the Policy. Sickness does not include elective or cosmetic surgery or procedures, or resulting complications. Sickness includes the donation of an organ in a non-experimental organ transplant procedure.

Spouse means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable federal law, state law, or law of the county, city or local government in Your jurisdiction of residence. A spouse may include Your same sex or opposite sex domestic or civil union partner or equivalent if:

a) for residents of the state of New York, You and such person demonstrate unilateral economic dependency or mutual economic interdependency; and
b) You submit to the Policyholder or Benefits Administrator a written declaration of partnership signed by You and Your partner in a form acceptable to Us; or
c) You submit evidence acceptable to Us that all applicable requirements of the jurisdiction in which you reside regarding the establishment of a domestic or civil union partnership have been met; or
d) You and Your partner satisfy the Policyholder or Benefits Administrator's requirements for such partnerships.

You, Your, Insured Person means the Member who is insured under the Policy.

Group Voluntary Long-Term Disability Benefits

Independent Business Owners Benefits Association

Group Number: G000AKS5

United of Omaha Life Insurance Company

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

SERFF Tracking Number:	*MUTM-128441091*	*State:*	*Arkansas*
Filing Company:	*United of Omaha Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*ELLEN GRADY*		
TOI:	*H11G Group Health - Disability Income*	*Sub-TOI:*	*H11G.003 Long Term*
Product Name:	*2012 IBOBA (Amway) - 12345GCB-LTD-EZ 11*		
Project Name/Number:	*2012 IBOBA (Amway)/12345GCB-LTD-EZ 11*		

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	06/11/2012
Bypass Reason:	Not applicable for this filing.		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	06/11/2012
Bypass Reason:	Not applicable for this filing.		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	IBOBA Articles of Inc and Bylaws	Approved-Closed	06/11/2012

Comments:

Attachment:

IBOBA Articles of Inc & Bylaws.pdf

EXHIBIT A

AMENDED AND RESTATED BYLAWS OF INDEPENDENT BUSINESS OWNERS BENEFITS ASSOCIATION

ARTICLE I
Purposes – Powers

The purposes for which this corporation is formed and the powers which it may exercise are set forth in the Articles of Incorporation of the corporation.

ARTICLE II
Members

Section 1. Classes of Members. There shall be one class of membership in this corporation. The members shall not be entitled to vote.

Section 2. Qualification for Membership. Authorized Independent Business Owners and registered Members affiliated with Quixtar Inc., Quixtar Canada Corporation, Amway Dominican Republic, LLC and Amway Haiti Limited may be members of this corporation and pay such annual dues and assessments, if any, required by the board of trustees and these Bylaws.

Section 3. Non-Assignability. Membership in this corporation is not assignable by a member, nor shall membership in this corporation pass to any personal representative, heir or devisee.

Section 4. Withdrawal. A member of the corporation may withdraw from membership by delivering a written resignation to the Secretary.

Section 5. Suspension and Expulsion. A member may be suspended or expelled from membership with or without cause by a majority vote of the board of trustees.

ARTICLE III
Board of Trustees

Section 1. Number of Trustees. The entire board of trustees shall consist of three (3) trustees. The first board of trustees shall be those appointed by the incorporator. Thereafter, trustees shall be elected at the annual trustees' meeting, subject to the provisions of Section 2 and Section 3 of this Article, and shall hold office until a successor is elected.

Section 2. Vacancies. Vacancies on the board of trustees shall be filled by a majority vote of trustees then in office or by a majority vote of the board of directors of Quixtar Inc.

Section 3. Nomination of Trustees. The nominees for membership on the board of trustees shall be submitted by Quixtar Inc. acting through its board of directors.

Section 4. Powers. The board of trustees shall manage the affairs of the corporation and may exercise all the powers of the corporation as set forth in the Articles of Incorporation.

Section 5. Resignation and Removal. A trustee may resign at any time by written notice to the corporation. A trustee may be removed with or without cause by a majority vote of the trustees entitled to vote at an election of trustees or by a majority vote of the board of directors of Quixtar Inc.

Section 6. Committees of Trustees. The board of trustees may designate such committees of its members as it may deem advisable.

ARTICLE IV
Meetings of the Trustees

Section 1. Times and Places of Meetings. Meetings of the board will be held at the time and place fixed by the board.

Section 2. Annual Meeting. An annual meeting of the board for the purpose of electing trustees and officers and for other purposes shall be held on the last Friday in May of each year (unless such day shall be a holiday, in which case it shall be on the next following business day), or at such other time and place set by the board of trustees.

Section 3. Notice of Annual Meeting. Written notice of the annual meeting of trustees stating the time, place and purposes of the meeting shall be given either personally or by mail to each trustee not less than 10 nor more than 60 days prior to the date fixed for the meeting.

Section 4. Special Meetings. Special meetings of the board may be called by the board of trustees, the President, or the Secretary.

Section 5. Notice of Special Meetings. Written notice of special meetings stating the time, place and purposes of the meetings shall be given to each trustee. When provided personally or by telegram, the notice shall be given two days in advance of the date fixed for the meeting. When provided by mail, the notice shall be sent five days in advance of the date fixed for the meeting.

Section 6. Waiver of Notice of Meetings. Notice of any meeting of the board of trustees need not be given to any person who signs a waiver of notice before or after the meeting. Attendance of a trustee at a meeting of the board constitutes a waiver of notice of such meeting, except when the trustee protests at the beginning of the meeting that the meeting is not lawfully called or convened.

Section 7. Quorum. A majority of the trustees shall constitute a quorum for the transaction of business and the act of a majority of those trustees present at any meeting at which there is a quorum shall be the act of the board, except as provided by law or by the Articles of Incorporation.

Section 8. Vote Required. Trustees of the corporation shall be elected by a plurality of votes cast. All other actions shall be authorized by a majority of the votes cast, except as otherwise provided by these Bylaws.

Section 9. Voting Rights. Each trustee present in person at a meeting of the board shall be entitled to one vote.

Section 10. Conduct of Meetings. Meetings of trustees generally shall follow accepted rules of parliamentary procedure, except the Chairperson of the board shall have authority over matters of procedure and may adopt any other form of procedure suited to the business being conducted.

Section 11. Action Without a Meeting. Unless otherwise restricted by the Articles of Incorporation, any action may be taken without a meeting, prior notice or vote, if a written consent is signed by all members of the board of trustees.

Section 12. Participation by Telephone. Any or all members of the board of trustees or members of any committee may participate in a meeting by means of conference telephone call by which all persons participating in such meeting can hear each other, and participation in such conference telephone call shall constitute presence in person at the meeting.

ARTICLE IV
Officers

Section 1. Appointment. The board at its annual meeting shall appoint a President, Secretary, and Treasurer. The board may also appoint a Chairperson of the board and one or more Vice Presidents. Only the Chairperson of the board need be a trustee. Any two or more offices may be filled by the same person.

Section 2. Resignation and Removal. An officer may resign at any time by written notice to the corporation. An officer may be removed with or without cause by a vote of the board, except as provided by law.

Section 3. Chairperson of the Board. The Chairperson of the board, if there be one, shall, when present, preside at all meetings of trustees. The Chairperson shall have such other duties and powers as the board of trustees shall authorize.

Section 4. President. The President shall be the chief executive officer and, unless the Chairperson of the board is present, shall preside at all meetings of trustees. The President shall sign bonds, mortgages, and other contracts and agreements on behalf of the corporation except when the board of trustees shall instruct the same to be done by some other officer or agent. The

President shall see that all orders and resolutions of the board of trustees are carried into effect and shall perform all other duties necessary or appropriate to the office of the President.

Section 5. Vice President. Each Vice President shall have such title and perform such duties assigned by the President or the board of trustees.

Section 6. Secretary. The Secretary shall maintain the minutes of all meetings of the board of trustees and shall perform such duties assigned by the President or the board of trustees.

Section 7. Treasurer. The Treasurer shall have the custody of the corporate funds and securities except as otherwise provided by the board of trustees, shall keep full and accurate accounting records for the corporation, and shall deposit all funds to the credit of the corporation in such depositories as may be designated by the board of trustees.

Section 8. Other Officers. Other officers may from time to time be appointed by the board of trustees to perform such duties and exercise such authority as the board of trustees shall prescribe.

ARTICLE V
Indemnification

Section 1. Indemnification. The corporation may indemnify its trustees, officers, employees and agents against expenses (including attorney's fees), judgments, fines, and amounts paid in settlement actually and reasonably incurred by them in connection with any actions or suits brought or threatened against them, including actions by or in the right of the corporation, by reason of the fact that such person was serving as a trustee, officer, employee, or agent of the corporation, to the fullest extent provided by law.

Section 2. Authorization of Indemnification. Indemnification shall be made (unless ordered by court or provided by law) only upon determination that such trustee, officer, employee or agent has acted in good faith and in the best interests of the corporation. Such determination shall be made (1) by majority vote of a quorum of trustees, who were not parties to such action or suit, or (2) if a quorum of disinterested trustees directs, by written opinion of legal counsel for the corporation or by other independent legal counsel.

Section 3. Insurance. The corporation may purchase and maintain insurance on behalf of any person who is or was a trustee, officer, employee or agent of this corporation or is or was serving at the request of the corporation in any other enterprise against any liability incurred in such capacity.

ARTICLE VI
General Provisions

Section 1. Checks. All checks or demands for money and notes of the corporation shall be signed by such persons as the board of trustees may designate.

Section 2. Fiscal Year. The fiscal year of the corporation shall be fixed by the board of trustees.

Section 3. Seal. The board of trustees may adopt a corporate seal.

Article VII
Amendment of Bylaws

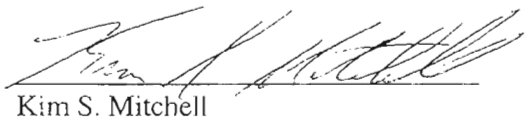
These Bylaws may be amended or repealed only by the affirmative vote of a majority of the entire board of directors of Quixtar Inc.

CERTIFICATE

I, Kim S. Mitchell, Assistant Secretary of Independent Business Owners Benefits Association, hereby certify that the foregoing Amended and Restated Bylaws of the Independent Business Owners Benefits Association were duly and lawfully adopted as and for the Bylaws of said corporation by unanimous written consent of the Board of Directors of Quixtar Inc. on October 1, 2002, and hereby further certify that the foregoing constitute the Bylaws of said corporation.

Dated: October 1, 2002

Independent Business Owners Benefits Association

By: 
Kim S. Mitchell
Assistant Secretary

BCS/CD-515 (Rev. 04/11)

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMERCIAL SERVICES

Date Received	(FOR BUREAU USE ONLY)
	This document is effective on the date filed, unless a subsequent effective date within 90 days after received date is stated in the document.

Name		
Michael P. Robach, Corporate Counsel, Amway Corp.		
Address		
7575 Fulton Street East		
City	State	Zip Code
Ada	Michigan	49355-0001

EFFECTIVE DATE:

Document will be returned to the name and address you enter above.
If left blank document will be mailed to the registered office.

CERTIFICATE OF AMENDMENT TO THE ARTICLES OF INCORPORATION

For use by Domestic Profit and Nonprofit Corporations

(Please read information and instructions on the last page)

Pursuant to the provisions of Act 284, Public Acts of 1972 (profit corporations), or Act 162, Public Acts of 1982 (nonprofit corporations), the undersigned corporation executes the following Certificate:

1. The present name of the corporation is: **Independent Business Owners Benefits Association**

2. The identification number assigned by the Bureau is: **712183**

3. **Article II** of the Articles of Incorporation of Independent Business Owners Benefits Association is hereby amended in its entirety to read as follows:

Article II

Purposes and Powers

The purposes for which the corporation is organized are to promote the interests of the members of the corporation at the local, state and federal government levels, to use the power of group buying to make available to the members benefits and services such as travel programs, including automobile rental and hotel discounts, insurance, non-insurance healthcare discounts, and to provide educational information and forums.

The corporation may exercise generally any power which is consistent with the purposes described above and which a nonprofit corporation organized under the provisions of the Michigan Nonprofit Corporation Act may exercise. The corporation may deal with and distribute the corporation's property without limitation in such manner as will best promote its objectives and purposes.

4. **Article V** of the Articles of Incorporation of Independent Business Owners Benefits Association is hereby amended in its entirety to read as follows:

Article V

Limitation of Volunteer Trustee's and Officer's Liability
and
Assumption of Liability for Acts of Volunteer Trustees and Officers

A volunteer Trustee or volunteer officer of the corporation shall not be personally liable to the corporation for monetary damages for a breach of the Trustee's or officer's fiduciary duty, except that the liability of a Trustee or officer is not eliminated or limited for any of the following:

(1) a breach of the Trustee's or officer's duty of loyalty to the corporation;

(2) acts or omissions not in good faith or that involve intentional misconduct or a knowing violation of law;

(3) a violation of Section 551(1) of the Michigan Nonprofit Corporation Act, which section relates to the making of unauthorized dividends or distributions;

(4) a transaction from which the Trustee or officer derived an improper personal benefit;

(5) an act or omission that is grossly negligent; or

(6) an act or omission occurring before the effective date of this article granting limited liability.

The corporation shall assume the liability for all acts or omissions of a volunteer Trustee or volunteer officer if all of the following conditions are met:

(1) the volunteer was acting or reasonably believed he or she was acting within the scope of his or her authority;

(2) the volunteer was acting in good faith;

(3) the volunteer's conduct did not amount to gross negligence or willful and wanton misconduct;

(4) the volunteer's conduct was not an intentional tort; and

(5) the volunteer's conduct was not a tort arising out of the ownership, maintenance, or use of a motor vehicle for which tort liability may be imposed as provided by Section 3135 of the Michigan Insurance Code of 1956.

If the Michigan Nonprofit Corporation Act is amended to further eliminate or limit the liability of a volunteer director, trustee or officer, then a volunteer Trustee or officer (in addition to the circumstances in which a Trustee or officer is not personally liable as set forth in the preceding paragraph) shall, to the fullest extent permitted by the Michigan Nonprofit Corporation Act as so amended, not be liable to the corporation. No amendment to or alteration, modification or repeal of this Article shall increase the liability or alleged liability of any volunteer Trustee or officer of the corporation for or with respect to any acts or omissions of such Trustee or officer occurring prior to such amendment, alteration, modification or repeal.

Provisions of this article added by amendment shall apply only to acts or omissions and to breaches of duty occurring after the date the amended article was adopted.

No amendment to or alteration, modification or repeal of this article shall reduce the scope of the corporations assumption of liability under this article for or with respect to any volunteer's acts or omissions that occur before such amendment, alteration, modification or repeal.

5. **Article VII** of the Articles of Incorporation of Independent Business Owners Benefits Association is hereby amended in its entirety to read as follows:

Article VII

Amendments

The corporation may amend or repeal any provision contained in these Articles of Incorporation and add additional articles in the manner prescribed by statute.

6. **(For a nonprofit corporation whose Articles state the corporation is organized on a directorship basis.)**

The foregoing amendment to the Articles of Incorporation was duly adopted on the 15th day of September, 2011, by the directors of a nonprofit corporation whose articles of incorporation state it is organized on a directorship basis (check one of the following)

☐ at a meeting the necessary votes were cast in favor of the amendment

☒ by written consent of all directors pursuant to Section 525 of the Act.

Signed this 15th day of September, 2011

By _____
(Signature of President, Vice-President, Chairperson or Vice-Chairperson)

James B. Payne — President
(Type or Print Name) (Type or Print Title)

5686638-1